



DEPARTMENTS OF THE ARMY AND THE AIR FORCE  
NATIONAL GUARD BUREAU  
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NGB-ARS (50)

22 November 1999

MEMORANDUM FOR THE ADJUTANTS GENERAL OF ALL STATES, PUERTO  
RICO, THE VIRGIN ISLANDS, GUAM, AND THE DISTRICT  
OF COLUMBIA

SUBJECT: All States (Log Number P99-0055) Army National Guard Anthrax Vaccine  
Immunization Program (AVIP) Implementation Policy

1. REFERENCES:

- a. Army Anthrax Vaccine Immunization Program Plan, 29 Apr 98.
- b. Memorandum, SECDEF, 18 May 98, Subject: Implementation of the Anthrax  
Vaccination Program for the Total Force.
- c. Memorandum, OUSD-M&RA, 30 Mar 99, Subject: Change to Anthrax Vaccine  
Immunization Program (AVIP) Operational Procedure (One Day Policy).
- d. Memorandum, NGB-ZA, 27 Jul 99, Subject: National Guard Anthrax Vaccine  
Immunization Program (AVIP).
- e. Memorandum, NGB-ARZ-HRP, 22 Apr 99, Subject: Army National Guard  
Immunization Policy.
- f. Department of Defense Directive (DoDD) 6205.3, DoD, 26 Nov 93, Subject:  
Immunization Program for Biological Warfare Defense.
- g. Army Regulation 40-68, Quality Assurance Administration, 30 Jun 95.
- h. Army Regulation 600-20, Army Command Policy, 30 Mar 88.
- i. All Army Activity (ALARACT) Message 018/99, DTG 080433Z MAR 99, Subject:  
Army Immunization Policy (AR 600-20, Para. 5-4).
- j. Air Force Joint Instruction 48-110, Army Regulation 40-562, BUMEDINST  
6230.15, and CG COMDTINST M6230.4E, Immunizations and Chemoprophylaxis,  
1 Nov 95.

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k. Michigan Department of Public Health, Package Insert, Anthrax Vaccine Adsorbed, 1987.

l. Federal Strategic Health Alliance Paper, undated.

m. Draft Memorandum of Understanding between the Veterans Health Administration and the United States Army.

n. Memorandum, OASD-RA, 20 Jul 99, Subject: Ensuring Reserve Component Have Full Access to Department of Defense (DoD) Military Treatment Facilities (MTF) for Treatment and Evaluation of Adverse Events from DoD Directed Immunizations.

## 2. BACKGROUND:

a. In an effort to protect our Total Force against the threat of anthrax exposure, the Secretary of Defense (SECDEF) released a policy on 15 Dec 97, to start immunizing DoD personnel deploying into High Threat Areas (HTA) against anthrax. The policy also directed that the Anthrax Vaccine Immunization Program (AVIP) would be tracked by a centralized DoD-wide system and would be given to all military service members, mission-essential Army civilians, and mission-essential DoD contract civilians.

b. In accordance with the SECDEF policy, the Chief, National Guard Bureau directs the implementation of the AVIP. This policy guidance is provided to assist with the implementation of the anthrax program and to ensure that maximum protection is provided to ARNG personnel.

c. The AVIP is an essential force protection program. This particular immunization is unprecedented in complexity due to the multiple immunizations required by the Food and Drug Administration (FDA) licensed protocol. The concept of force protection, however, is not new. Planning for the AVIP has involved the development of innovative and flexible tools for the commander to use in executing this and subsequent force protection programs.

d. Weaponized anthrax poses a real and present danger to our soldiers. The anthrax vaccine offers what is simply the best available protection against this deadly threat. We owe every one of our soldiers nothing less than the optimal safeguard that this vaccination represents. Despite this commitment to force protection, some service members have opted to disobey a lawful order by refusing the vaccination.

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e. This program has congressional oversight and requires monthly update reports to the Vice Chief of Staff of the Army, who serves as executive agency. Reports are produced from the DoD tracking systems that interfaces with DEERS. This centralized tracking system allows all services a means to input data for administered immunizations, and to track the six shot immunization schedule for each person, regardless of where a vaccine is administered.

f. The AVIP was developed with significant safeguards designed to ensure accurate record keeping and soldier safety. Effective and accurate education is essential for the success of the AVIP.

### 3. RESPONSIBILITIES:

a. The AVIP is a command program. Commanders will ensure that service members scheduled for ODT, TDY, IPRs, or other duty to the HTAs initiate enrollment into the AVIP. The FDA approved immunization schedule for this vaccine requires a series of six vaccinations (at 0, 2, and 4 weeks and 6, 12, 18 months) followed by annual boosters. Input into the tracking system must be accomplished within 24 hours of administering each injection. Commanders should ensure soldiers receive their next required immunization by scheduling them according to this FDA approved timeline.

b. Soldiers entering a HTA will begin the anthrax immunization series and upon return to home station, will continue the series. Due to the relatively small numbers of these soldiers and the fact that scheduling is largely an individual unit issue, close coordination of support services is essential to meet this requirement.

c. Coordinating anthrax immunizations to have a minimum adverse impact on training will require the involvement of the operations community. State surgeons and the Chief Surgeon, (NGB-ARS) will provide technical and clinical assistance. The actual planning and execution of the AVIP remains the responsibility, however, of commanders and their staff.

d. Each state is responsible to appoint an AVIP POC to work with NGB-ARS AVIP Program Manager as required. Commanders will designate an individual and an alternate responsible to coordinate the program and serve as the POC to the next higher headquarters. Intermediate headquarters will maintain a roster of AVIP POCs to facilitate rapid and effective coordination of actions.

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e. Commanders will identify the unit and home locations for those soldiers who reside an inordinate distance, as determined by the commander, from the unit location and may require supplemental services to complete the immunization regimen. A list of those soldiers who are not located near a DoD MTF should be forwarded, through the chain of command, to their state POC for further coordination with NGB-ARS for use of contract service providers.

#### 4. PHASED IMPLEMENTATION:

##### a. Phase I

(1) All U.S. military personnel and DoD emergency essential civilian employees and contractor personnel assigned, deployed, or on temporary duty in the HTAs and contiguous waters of Southwest Asia (Kuwait, Saudi Arabia, Bahrain, Jordan, Qatar, Oman, UAE, Yemen and Israel) and the Korean Peninsula for any period of time.

(2) Individuals who have already begun the anthrax immunization series.

(3) Army National Guard RAID Teams as first responders to possible Weapons of Mass Destruction incident within CONUS.

(4) Only personnel that fall into one of the categories cited above are authorized to receive anthrax immunization. Due to vaccine supply constraints, immunizations are authorized only for actual deployments into the HTAs and those who have begun the series, not for early deployers or "possible" deployers.

##### b. Phase II

(1) Commencement is contingent upon assured production of the anthrax vaccine and will be announced by SECDEF. Estimated date of April 2000 for early deploying forces (C to C+35) to the designated HTAs.

(2) Special Forces and other early deployers to HTAs.

c. Phase III: Mass immunization of the total force, accessions, and program sustainment currently scheduled to commence FY 03.

#### 5. COORDINATION:

a. Units located in proximity to an MTF should coordinate directly with that facility.

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Any MTF regardless of service are directed to provide support to ARNG personnel. Location information for vaccine is contained on Medical Protection System (MEDPROS) website.

b. Units and individuals not near an MTF will need to coordinate through their chain of command for use of contract provider support or organic resources in STARC Medical Detachment to receive immunizations. Tracking and data entry into MEDPROS will be a unit responsibility.

c. The state AVIP coordinator can request through NGB-ARS for contract provider support to administer the immunizations. This support is centrally funded through NGB and provided at no cost to the state. A memorandum of agreement (MOA) with the Division of Federal Occupational Health (FOH) to provide contract support is in effect. This MOA is a consolidated effort with the Office of the Surgeon General (OTSG), NGB and The Office of Chief, Army Reserve (OCAR).

d. A separate contract with a commercial private vendor has been awarded by Medical Command (MEDCOM) to provide force medical readiness support. This contract is centrally funded by NGB-ARS and will be available when service assessment and cost determination are finalized. Contract was awarded to provide medical physical exams, annual dental screening with x-ray capability, DNA, anthrax and other immunizations.

e. Under negotiation with the Veterans Health Affairs (VHA) is an additional MOA to provide force medical readiness support, to include, medical physical exams, annual dental screenings with x-ray capability, DNA, anthrax and other immunizations. This MOA will be centrally funded by NGB-ARS and made available when service assessment and cost determination are finalized.

f. A Federal Strategic Health Alliance (FSHA) is designed to support mass immunizations for units, individual, or small group inoculations at DoD MTF, VHA, and FOH locations. This DA-VHA-FOH consortium will provide a flexible and cost effective means for administering anthrax immunizations. The determination of which method is used to provide immunizations will vary by location and vaccination requirements and will be established during the coordination process. Generally, it is more cost effective to perform mass immunizations in conjunction with other unit training. Smaller numbers of soldiers or individuals requiring immunizations are more efficiently serviced at one of the points of service available through the FSHA.

## 6. DOCUMENTATION:

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a. Documentation of the anthrax immunizations is required in three areas – MEDPROS, Department of Health and Human Services Form PHS 731 (International Certificate of Vaccination), retained by the soldier, and SF 601 (Immunization Record), contained in the health record. The applicability of the Army's immunization tracking program, the MEDPROS will eventually be extended to cover all immunizations. The functionality of MEDPROS will also be integrated into future personnel systems architecture.

b. Successful execution of the AVIP requires accurate tracking and record keeping. The MEDPROS has been fielded in the STARCs through NGB MEDPROS training courses. The STARCs should field MEDPROS down to UIC level. The MEDPROS provides the capability to track personnel in the AVIP regardless of where the immunization was received. This system has multiple applications that will enhance unit readiness:

(1) The MEDPROS offers commanders a powerful tool to assist in the implementation of and in measuring unit compliance with the AVIP. It provides an effective and relatively simple means for the personnel community to track individual readiness.

(2) The MEDPROS also offers a reliable and accurate data repository, which provides world-wide visibility of immunizations and tracks conformity with the FDA approved immunization schedule for the anthrax vaccine.

c. The services are required by the Office of the Assistant Secretary of Defense (Reserve Affairs) to compile statistics on soldiers who refuse the anthrax vaccination. Soldiers refusing this inoculation will be reported through command channels to NGB-ARS AVIP Program Manager. Reportable information will include:

(1) Soldier's name.

(2) Unit.

(3) Date and time of refusal.

(4) Soldier's stated reasons for refusal.

(5) Actions taken (re-education, counseling, referral to a physician for additional information, etc.).

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(6) Disposition (i.e. soldier accepted immunization, soldier refused, action taken by the commander, etc.).

## 7. EDUCATION:

a. Education is a key factor of the ARNG AVIP program. Providing the mandatory anthrax briefing 30-60 days prior to scheduling first immunization is critical and historically has been instrumental in reducing the incidence of refusals of this immunization. Service members who fully understand the real and present threat presented by weaponized anthrax do not refuse this immunization. Similarly, their concerns are allayed when they become fully aware of the safety and efficacy of the vaccine and the extraordinary measures being employed to ensure it remains safe and effective.

b. Several briefings have been prepared in support of the AVIP. The leaders briefing and the clinicians briefing are most applicable to the immunization effort in units. These briefings are also periodically reviewed and updated to reflect the most current information and are available through the official AVIP website.

c. An interactive website is available at <http://www.anthrax.osd.mil>. This resource provides more detailed and the most current information. Efforts are underway to enhance the interactive nature of this communication outlet to provide rapid and relevant information.

d. Informational pamphlets, or "tri-folds," are available for leaders, soldiers, and family members and the civilian community. These are also reviewed and updated periodically.

e. A toll-free line and email address is available for soldiers to call with their unanswered questions. This is monitored Monday – Friday and questions will be answered within 24 hours at 877-GET-VACC or [avip@otsg-amedd.army.mil](mailto:avip@otsg-amedd.army.mil).

f. All briefing and tri-fold materials are available through command channels and from the website.

g. Briefings and tri-folds will also be provided to and available at FSHA locations.

h. Media inquiries concerning the AVIP will be referred to command public affairs channels.

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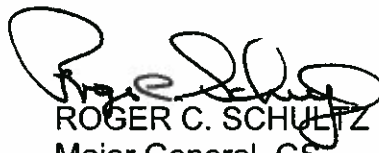
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i. Password for 'read-only' access to MEDPROS may be requested at [www.mods.asmr.com](http://www.mods.asmr.com).

8. This memorandum will expire one year from date of publication unless sooner rescinded or superseded.

9. The AVIP Program Manager for NGB-ARS is LTC Jane Monville at 703-607-7149, DSN 327-7149, or email [Jane.Monville@ngb-arng.ngb.army.mil](mailto:Jane.Monville@ngb-arng.ngb.army.mil).

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